ARTICLE I - DEFINITIONS

Accreditation –The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by a recognized industry standard accrediting agency. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and members a standard of comparison in evaluating health care organizations.

Action – Consistent with 42 CFR §438.400, action refers to the denial of a service authorization request; or the reduction, suspension, or termination of a previously authorized service; denial in whole or in part of a payment for a covered service (except where the provider's claim is denied for technical reasons including but not limited to prior authorization rules, referral rules, late filing, invalid codes, etc); or failure to provide services within the timeframes required in Article II.L and Article II.S of this Contract; or the denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) (described in Article II.S. of this Contract) to obtain services outside of the network.

Actuarially Sound Capitation Rates – As defined in 42 CFR 438.6 means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the contract; and have been certified as actuarially sound by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Annually – For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.

Appeal - In accordance with 42 CFR 438.400, an appeal is defined as a request for review of an action, as "action" is defined in this Contract.

Balanced Budget Act – Refers to the Balanced Budget Act (BBA) of 1997; final rule issued June 14, 2002; effective August 13, 2002. The BBA is the comprehensive revision to Federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Part 438 et. seq.

Business Days – Means Monday through Friday, 8:30 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.

Capitation Payment - A payment the Department makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular recipient receives services during the period covered by the fee.

Capitation Rate - The monthly rate, payable to the Contractor, per enrollee, for all expenses incurred by the Contractor in the provision of contract services as defined herein.

Case Management – The process of identification of patient needs and the development and implementation of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

Centers for Medicare and Medicaid Services (CMS) – (Formerly known as HCFA) The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.

Children With Special Health Care Needs (CSHCN) – Children with special needs have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include the children in the eligibility category of SSI participation.

Claim – An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the HCFA 1500, UB-92, and/or ADA Dental claim forms.

Clean Claim - A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act.

Client, Recipient, Enrollee, Member or Participant - means an individual having current Medicaid/FAMIS Plus eligibility who shall be authorized by the Department to participate in the Medallion II program.

Cold Call Marketing – Any unsolicited personal contact with a potential enrollee by an employee, affiliated provider or contractor of the entity for the purpose of influencing enrollment with such entity.

Complaint – A grievance.

Consumer Assessment of Health Plans Survey (CAHPS™) – A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Health Care Policy and Research, the Research Triangle Institute and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of managed care plans.

Contract - This signed and executed document.
Contract Modifications - Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.

Contractor - Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department's capability for effective administration of the program.

Cost Sharing – Co-payments paid by the enrollee in order to receive medical services.

Days - Business days, unless otherwise specified.

Department - The Virginia Department of Medical Assistance Services.

Disenrollment - The process of changing enrollment from one Medallion II MCO plan to another MCO or to the Department's Primary Care Case Management (PCCM) program, if applicable.

Drug Efficacy Study Implementation (DESI) – Drugs for which DMAS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

Early Intervention – As defined in the Virginia Code § 2.2-5300, are those services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. The Contractor shall cover medically necessary services, including rehabilitative therapies within the amount duration and scope as defined in 12VAC30-130-10 and 12VAC30-50-200. All services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice. This includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) - Those services defined by Federal law in Section 1905(r) of the Social Security Act, 42 USC §1396 d

(r), to include screening and diagnostic services to determine physical or mental defects in recipients under age twenty-one (21), and health care, treatment, and all other measures to correct or ameliorate any defects and chronic conditions discovered.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency Room Assessment Fee (Triage Fee) - The fee paid for all non-emergency claims for services delivered in the emergency room. The fee has two (2) components: a facility component and a physician component. The facility component is reimbursed using an all-inclusive fee that approximates the fee for an intermediate emergency room visit. The physician component is reimbursed using an all-inclusive fee that approximates the fee for a brief physician office visit for a new patient.

Emergency Services - Those health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or,
3. Serious dysfunction of any bodily organ or part.

Encounter – Any covered or enhanced service received by an Enrollee through the Contractor.

Encryption – A security measure process involving the conversion of data into a format which cannot be interpreted by outside parties.

Enhanced Services - Services offered by the Contractor to enrollees in addition to Medallion II covered services. The Department will not pay for enhanced services.

Enrollee - A person eligible for Medicaid/FAMIS Plus who is enrolled with an MCO Contractor to receive services under the provisions of this Contract.

Enrollee Handbook – Document required by the contract to be provided by the MCO to the enrollee prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, enrollee

eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, enrollee services, emergency care, enrollee identification cards, enrollee responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

Enrollment - The completion of approved enrollment forms by or on behalf of an eligible person and assignment of a recipient to an MCO by the Department in accordance with the terms of this Contract.

Enrollment Area - The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia, pursuant to a Contract, to operate as a Medallion II Contractor and in which service capability exists as defined by the Commonwealth.

Enrollment Broker - An independent broker who enrolls recipients in the Contractor plan and who is responsible for the operation and documentation of a toll-free recipient service helpline. The responsibilities of the enrollment broker include, but are not limited to, recipient education and enrollment, assistance with and tracking of recipient's grievance resolution, and may include recipient marketing and outreach.

Enrollment Period – The time that a recipient is enrolled in a Department approved MCO during which they may not disenroll or change MCOs unless disenrolled under one of the conditions described in Article II and pursuant with Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve months.

Evidence of Coverage - Any enrollment package that includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

Excluded Entity - Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined in Article II, Section K.6, of this Contract.

Exclusion from Medallion II - The removal of an enrollee from the Medallion II program on a temporary or permanent basis.

Expedited Appeal –The process by which an MCO must respond to an appeal by a recipient if a denial of care decision by an MCO may jeopardize life, health or ability to regain maximum function. The decision must be rendered within three (3) business days of the recipient appeal.

External Quality Review (EQR) – Analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services

that a MCO or their contractors furnish to Medicaid recipients, as defined in 42 CFR 438.320.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, and other EQR related activities as set forth in 42 CFR 438.358.

Family Planning –Those services necessary that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

Family Planning Waiver – A Medicaid Research and Demonstration Waiver available to women of child-bearing years (9 to 57 years of age) who received a Virginia Medicaid-reimbursed pregnancy related service on or after October 1, 2002, who is less than 24 months post-partum, who has income less than or equal to 133% of the Federal Poverty Level, and who has not otherwise been determined eligible for Virginia Medicaid coverage.

FAMIS Plus Recipients – Children under the age of 19 who meet "medically indigent" criteria under Medicaid program rules, and who are assigned an aid category code of 90; 91 (under 6 years of age); 92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost sharing responsibilities. Additionally, for the terms set forth in this Contract, FAMIS Plus and Medicaid enrollees shall be treated in the same manner. Any information sent to FAMIS Plus and Medicaid enrollees must appropriately address the entire intended population. For example, all marketing and benefit materials cannot specify "Medicaid" unless they also specify "FAMIS Plus." If the material does not specify "Medicaid," it does not need to specify "FAMIS Plus."

Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.

Fee-for-Service - The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This method of reimbursement is not used by the Department to reimburse the Contractor under the terms of this Contract.

Flesch Readability Formula - The formula by which readability of documents is tested as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974).

Formulary – A list of drugs that the MCO has approved. Prescribing some of the drugs may require prior authorization.

Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.

Generally Accepted Accounting Principles (GAAP) - Uniform minimum standards of and guidelines to financial accounting and reporting as established by the Financial Accounting Standards Board and the Governmental Accounting Standards Board.

Grievance - In accordance with 42 CFR § 438.400, grievance means an expression of dissatisfaction about any matter other than an "action." Grievance is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

Guardian – An adult who is legally responsible for the care and management of a minor child.

Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.

Home and Community-Based Care Services (HCBS) - Medicaid community-based care programs operating in the Commonwealth under the authority of §1915(c) of the Social Security Act, 42 U.S.C. §1396 n (c) including, but not limited to, the waivers for AIDS, Elderly and Disabled (E&D), Consumer Directed Personal Attendant Services (CDPAS), Mental Retardation, Technology Assisted, and Individual and Family Developmental Disabilities Support (DD).

Hospital - A facility that meets the requirements of 42 C.F.R. § 482, as amended.

Informational Materials – Written communications from the Contractor to enrollees that educates and informs enrollees about services, policies, procedures, or programs specifically related to Medicaid/FAMIS Plus.

Initial Implementation - The first time a program or a program change is instituted in a geographical area by the Department.

Inquiry – An oral or written communication usually received by a Member Services Department or telephone help line representative made by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received, etc., 2) provision of

information regarding a change in the member's status such as address, family composition, etc., or; 3) a request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.

Intermediate Care Facility for the Mentally Retarded - Intermediate care facility/mental retardation (IFC/MR) is a facility, licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), in which care is provided to mentally retarded individuals who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming, boarding home, or group home. Such facilities must comply with Title XIX standards, provide health or rehabilitative services, and provide active treatment to clients toward the achievement of a more independent level of functioning.

Laboratory - Any laboratory performing testing for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 C.F.R. § 493.3, as amended.

Managed Care Organization (MCO) –An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with DMAS to provide services covered under the Medallion II program. Covered services for Medallion II individuals must be accessible (in terms of timeliness, amount, duration, and scope) as compared to other Medicaid recipients served within the area.

Marketing Materials - Any materials that are produced in any medium, by or on behalf of an MCO; are used by the MCO to communicate with individuals who are not its enrollees; and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.

Marketing Services - Any communication, services rendered or activities conducted by the Contractor or its subcontractors to its prospective enrollees for the purpose of education or providing information that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's Medicaid/FAMIS Plus product.

Medallion II Carved-Out Services - The subset of Medicaid/FAMIS Plus covered services which the Contractor shall not be responsible for covering under the Medallion II program.

Medallion II Covered Services - The subset of Medicaid/FAMIS Plus covered services which the Contractor shall be responsible for covering under the Medallion II program.

Medicaid/FAMIS Plus Covered Services - Services as defined in the Virginia State Plan for Medical Assistance or State regulations.

Medicaid Fraud Control Unit - The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for in the Code of Virginia § 32.1-320, as amended.

Medicaid Management Information System (MMIS) - The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.

Medicaid/FAMIS Plus Non-Covered Services - Services not covered by DMAS and, therefore, not included in covered services as defined in the Virginia State Plan for Medical Assistance or State regulations.

Medicaid Recipient - Any individual enrolled in the Virginia Medicaid program.

Medical Necessity - "Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

Monthly – For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

Network Provider - The health care entity or health care professional who is either employed by or has executed an agreement with the Contractor, or its subcontractor, to render covered services, as defined in this Contract, to enrollees.

Newborn Guarantee Coverage Period - The time period between the date of birth of a child whose mother is a Medicaid/FAMIS Plus enrollee with the Contractor until the last day of the third month including the month of birth, unless otherwise specified by the Department. For example, a baby born any day in February will be enrolled with the Contractor until April 30.

Non-participating Provider - A health care entity or health care professional not in the Contractor's participating provider network.

Open Enrollment – Time frame defined by CMS as 60 days prior to the end of the recipient's enrollment. Before this 60-day time frame, recipients must be notified of their ability to disenroll or change plans at the end of their enrollment period.

Out-of-Network Coverage - Coverage provided outside of the established MCO network; medical care rendered to an enrollee by a provider not affiliated with the Contractor or contracted with the Contractor.

Party in Interest - Any director, officer, partner, agent, or employee responsible for management or administration of the Contract; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five (5) percent of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation or other nonprofit organization, an incorporation or enrollee of such corporation under applicable State corporation law. Additionally, any organization in which a person previously described is a director, officer or partner, that has directly or indirectly a beneficial interest of more than five (5) percent of the equity of the Contractor or has a mortgage, deed of trust, note, or other interest valuing more than five (5) percent of the assets of the Contractor; any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or any spouse, child, or parent of a previously described individual.

Person with Ownership or Control Interest - A person or corporation that owns, directly or indirectly, five (5) percent or more of the Contractor's capital or stock or received five (5) percent of the total assets of the Contractor in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, or is an officer, director, or partner of the Contractor.

Post Stabilization Services – Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

Potential Enrollee – A Medicaid/FAMIS Plus recipient who is subject to mandatory enrollment in a given managed care program. [42CFR438.10(a)]

Previously Authorized – As described in 42 CFR 438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment, and is best clarified by the following example. If the Contractor authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the example whereby (1) the MCO authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the MCO. In this case, the fact that the Contractor had authorized 10 visits on a prior request for authorization is not

germane to continuation of benefits requirements for previously authorized services that are terminated, suspended or reduced.

Primary Care Case Management (PCCM) - A system under which a primary care case manager contracts with the Commonwealth to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to recipients.

Primary Care Provider (PCP) - A practitioner who provides preventive and primary medical care for eligible recipients and who certifies prior authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

Quarterly – For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter.

Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.

Rural Area - A census designated area outside of a metropolitan statistical area.

Rural Health Clinic - A facility as defined in 42 C.F.R. § 491.2, as amended.

School Health Services- School health services are defined as physical therapy, occupational therapy, speech therapy, nursing, school health assistant, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC §1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions, as described in 12 VAC 30-50-229.1.

School health services are carved out of the contract and are reimbursed directly by DMAS. In order to receive DMAS reimbursement for school health services:

1. Services must meet DMAS' medical necessity criteria.
2. The school division must be enrolled with DMAS as a provider.
3. Claims for all school health services must be billed to DMAS by the school division using the school division's Medicaid provider number. These school health services

include those services provided by either the school division and/or provided by the school division's contractor(s).

4. DMAS will not directly reimburse contractors of school divisions for school health services. DMAS considers the school division responsible for payments to providers with whom the school division negotiates contracts.

Service Authorization Request – A managed care enrollee's request for the provision of a service.

State Fair Hearing – The Department's evidentiary hearing process. Any "action" or appeal decision rendered by the MCO may be appealed by the enrollee to the DMAS Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 CFR § 431.200 through 431.250 and 12 VAC30-110-10 through 12VAC30-110-380.

State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.

Subcontract - A written contract between the Contractor and a third party, under which the third party performs any one or more of the Contractor's obligations or functional responsibilities under this Contract.

Subcontractor - A State approved entity that contracts with the Contractor to perform part of the Contractor's responsibilities under this Contract. For the purposes of this Contract, the subcontractor's providers shall also be considered providers of the Contractor.

Successor Law or Regulation - That section of Federal or State law or regulation which replaces any specific law or regulation cited in this Contract. The successor law or regulation shall be that same law or regulation if changes in numbering occur and no other changes occur to the appropriate cite. In the event that any law or regulation cited in this Contract is amended, changed or repealed, the applicable successor law or regulation shall be determined and applied by the Department in its sole discretion. The Department may apply any source of law to succeed any other source of law. The Department shall provide the Contractor written notification of determination of successor law or regulation.

Temporary Detention Order (TDO) - An emergency custody order by sworn petition to any magistrate to take into custody a person believed to be mentally ill and in need

of hospitalization and transported to a location to be evaluated pursuant to 42 C.F.R. 441.150 and Code of Virginia, 16.1- 335 et. seq. and 37.1-67.1 et seq.

Third-Party Liability - Any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Urban Area - Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of "extended cities" according to the US Department of Commerce, Bureau of the Census.

Urgent Medical Condition - A medical (physical, mental or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

a) Placing the patient's health in serious jeopardy;
b) Serious impairment to bodily function;
c) Serious dysfunction of any bodily organ or part; or
d) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Value-Added Network (VAN) - A third party entity (e.g. vendor) that provides hardware and/or software communication services, which meet the security standards of telecommunication.